Children's Special Health Care Services (CSHCS) Application

Michigan Department of Community Health

INSTRUCTIONS:

- Enter information in ALL sections.
- Please PRINT clearly.
- If you have any questions, please call **1-800-359-3722.**

☐ Check here if the Local Health Department helped you fill out this form.

- Keep the PINK copy for your records.
- Mail the WHITE and YELLOW copies of this form and a photocopy of your insurance card(s) in the enclosed envelope to:

CSHCS DIVISION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30734
LANSING MI 48909-8234

SECTION 1 - Client Information (Adult Applicant OR Minor or Dependent Child):

1. Client Name (Last, First, Middle)			2. This Application is: ☐ **NEW** ☐ **RENEWAL**	3. If Renewal, Client ID No.
4. Client's Home Address (Number and Street, Apartment No.)			5. Client's Social Security No. - -	6. Sex ☐ **MALE** ☐ **FEMALE**
City	State	ZIP Code	7. Date of Birth	8. ☐ **Check if Child has Died**
9. County Client Lives in		10. U.S. Citizen? ☐ **YES** ☐ **NO**	11. Michigan Resident? ☐ **YES** ☐ **NO**	12. Migrant? ☐ **YES** ☐ **NO**
13. Home Phone ( ) -		14. Work Phone ( ) -	15. Message Phone (where you can be left a message) ( ) -	
16a. Is this person adopted?		16b. Date of Adoption	16c. Previous Complete Name (if different)	

17. Racial/ Ethnic Heritage (Check One) (You are not required to complete this information.)

☐ **ALASKAN NATIVE** ☐ **ARABIC** ☐ **BLACK** ☐ **WHITE**
☐ **AMERICAN INDIAN** ☐ **ASIAN OR PACIFIC ISLANDER** ☐ **HISPANIC** ☐ **MULTI-RACIAL/ ETHNIC**

SECTION 2 - Parent/Legal Guardian Information:

18. Name of Parent(s) or Legal Guardian(s) (Last, First, Middle)			
19. Home Address (if Different from Client's)		20. Home Phone Number -	21. Work Phone Number ( ) -
City	State	ZIP Code	22. Social Security Number(s) - -

SECTION 3 – Health Coverage and Other Information:

23. Is this client receiving any of the following now? *(check all that apply)*		24. Are the major health problems related to an accident or birth Injury?
☐ **MEDICAID** ID#: _____	☐ **MEDICARE - A** Claim #: _____	☐ YES ☐ NO
☐ **MIChild** *(see #25 below)*	☐ **MEDICARE - B** Claim #: _____	
25a. If enrolled in the **MIChild** program, enter the Name of the MI Child Health and Dental plans		25b. Policy or Medical Record No.

26. Other Insurance Policies that cover this Client for Health, Dental, Pharmacy or Vision Care Services.

A	Name of Policy Holder		Social Security Number - -	What type of insurance? ☐ **HEALTH** ☐ **PHARMACY** ☐ **DENTAL** ☐ **VISION**
	Name of Insurance Company	Employer Name	Policy Number	
B	Name of Policy Holder		Social Security Number - -	What type of insurance? ☐ **HEALTH** ☐ **PHARMACY** ☐ **DENTAL** ☐ **VISION**
	Name of Insurance Company	Employer Name	Policy Number	
C	Name of Policy Holder		Social Security Number - -	What type of insurance? ☐ **HEALTH** ☐ **PHARMACY** ☐ **DENTAL** ☐ **VISION**
	Name of Insurance Company	Employer Name	Policy Number	

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SECTION 4 - Doctor Information:

27. Enter **PRIMARY CARE DOCTOR**:

NAME OF **PRIMARY CARE** DOCTOR (First and Last)	DOCTOR'S ADDRESS (Number & Street, Suite, City, State, ZIP Code)	SPECIALTY AREA (If Known)	PHONE NUMBER
			( ) -

28. List **ALL OTHER** doctors (including specialists) who are treating the Client:

NAME OF **OTHER** DOCTORS (First and Last)	DOCTOR'S ADDRESS (Number & Street, Suite, City, State, ZIP Code)	SPECIALTY AREA (If Known)	PHONE NUMBER
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -

SECTION 5 - Other Health Care Provider Information: *(Use Additional Sheets if Needed)*

29. List all OTHER health care providers (including hospitals, therapists, equipment and medical suppliers). Include their Name, Address and what Health Care, Supplies, or Equipment they provide to the Client.

NAME OF PROVIDER	PROVIDER'S ADDRESS (Number & Street, Suite, City, State, ZIP Code)	SERVICES PROVIDED	PHONE NUMBER
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -
			( ) -

SECTION 6 - Medical Equipment, Supplies, or Special Services:

30. **Check (X)** any Medical Equipment, Supplies, or Special Services the Client uses now:

- ☐ **Apnea Monitor**
- ☐ **Oxygen/Pulse Oximeter**
- ☐ **Ventilator/CPAP**
- ☐ **Tracheostomy Supplies/Suction Machine**
- ☐ **Nebulizer**
- ☐ **Glucometer**
- ☐ **Gastrostomy/Ostomy Supplies**
- ☐ **Hearing Aids**
- ☐ **Seating/Mobility Services**
- ☐ **Incontinence Supplies**
- ☐ **I.V. Supplies, TPN, Feeding Pump**
- ☐ **OTHER:** *(List below)*

31. List the Client's current medications.

32. What are the Client's major health problems?

SECTION 7 - List all others in Household with CSHCS Coverage:

Client Name	CSHCS ID Number	Birth Date
Client Name	CSHCS ID Number	Birth Date

SECTION 8 - Agreement, Certification and Signature of Applicant:

- By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.
- I understand that I may need to show proof of this information.
- I agree that the Department of Community Health and its agents or contractors may get and share information to determine the Client's eligibility or need for specific services, to coordinate the provision of services, or for other administrative purposes related to the Children's Special Health Care Services (CSHCS) program, treatment, operations and payment.
- I understand that the information they share might relate to HIV, ARC, or AIDS if the Client has those conditions.

NOTE: CSHCS coverage for the client usually begins on the date this form is signed if received by CSHCS within 30 days of the signature date. If there are unpaid medical expenses for the client that are not the responsibility of another insurer (private insurance, Medicaid, Medicare, etc.), coverage may be requested for up to three months before the usual coverage begin date. CSHCS pays for CSHCS covered specialty care only to providers who participate with CSHCS.

33. SIGNATURE OF APPLICANT OR LEGALLY RESPONSIBLE PARTY — DATE SIGNED

35. REQUESTED CSHCS COVERAGE BEGIN DATE:

34. THE APPLICANT IS A/AN:

- ☐ **PARENT of Minor Client**
- ☐ **GUARDIAN of Client**
- ☐ **ADULT Applicant**

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary, but is required if CSHCS program services are desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

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